DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED

PRINTED: 05/01/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G159	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	6613 6TH STREET, NW WASHINGTON, DC 20012

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W 000	INITIAL COMMENTS A recertification survey was conducted from April 10, 2007 through April 13, 2007. This survey was initiated utilizing the fundamental survey process. Seven females with various degrees of disabilities reside in the facility. The survey sample was derived from a random sampling of four of the seven clients. The survey findings were based on observations in the group home and three day programs, interviews with clients, family member/guardians, staff and consultants. Also, the findings were based on review of records to include unusual incidents and investigation reports. NOTE: Prior to the recertification survey, the state regulatory agency received the facility's internal investigative report on March 22, 2007. The investigation determined that Client #1 had been abused by Direct Care Staff #1 on February 18, 2007. The investigative report documented that Direct Care Staff #2 who witnessed Direct Care Staff #1 speaking to client #1 in a harsh voice and threatened to withhold food, but did not report this incident two days later on February 20, 2007. Based on the investigative findings, the facility's management placed both Direct Care Staff (#1 and #2) on administrative leave immediately upon notification. The internal investigative report recommended the following actions to be taken by the facility: 1. Implement disciplinary action on the staff person to include termination for abuse to the resident; 2. Implement disciplinary action on the staff witnessing the incident of suspension and	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

QMRP — 5/10/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 mandatory training; 3. Immediate mandatory incident report training for all residential/nursing staff; 4. Staff to be retrained on Client #1's Behavior Support Plan in the next 30 days; 5. Staff to be retrained on how to support Client #1 (weekday/weekend) in the next 30 days; 6. Staff to be retrained on how to document, to include the importance of daily/time documentation as review of records show that this is not done in the next 30 days; 7. QMRP to further address Client #1's behavioral issues with the Interdisciplinary team and to discuss this recent incident with the Human Rights Committee; and 8. Conduct bi-weekly meetings with the residents to allow them to discuss their concerns. The surveyor determined that the facility had addressed these recommendation and implemented a system to ensure that clients were not subjected to further abuse.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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W 124	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the rights of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of four clients included in the sample. (Client #3) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the Human Rights Committee Minutes (HRC) conducted on April 11, 2007 at 3:57 PM, revealed that Client #3 received Risperdal 3 mg for a trial of three months and was discontinued. Further review of the HRC minutes revealed that Client #3 received sedation (Valium 20 mg) prior to a GYN appointment. Although the QMRP indicated that the family (mother/neice) had been involved in the client's care, there was no evidence that the facility attempted to contact the family to obtain consent for medications and/or sedation. Review of psychological assessment dated July 24, 2006 reflected that Client #3 functions at the profound level of mental retardation and was incapable of independent decisions regarding medical treatment. Although the HRC approved the trial medications and sedation, there was no evidence that the risks and benefits of the potential side effects of sedation had been explained to the client, and/or her mother. No system had been established to provide guardianship for consent or legally sanctioned advocacy for Client #3.	W 124	W124 Although attempts were made to contact the sister of client #3, it was determined (by lack of response to correspondence and phone calls) that the family chooses not to be involved in her care at this time. Therefore, the QMRP will continue efforts toward the successful appointment of a guardian for legally sanctioned advocacy. (Note: Client #3's mother is deceased) 5/31/07	

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W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to implement an effective system to protect the clients' rights for privacy during personal care needs for two of seven clients residing in the facility. (Clients #1 and #7) The findings include: The facility failed to ensure the clients rights to privacy during care of personal needs for Client #1 and #7 as evidenced by the following: 1. During evening observations on April 10, 2007 beginning at 3:03 PM, Client #3 buttock was exposed each time she got up from the sofa and dining table. At no time did the direct care staff encourage or redirect Client #3 to pull down her shirt when getting up from the sofa. 2. Observations conducted on April 10, 2007 at approximately 6:03 PM revealed Client #7 coming out of her bedroom with her shirt up, exposing her bra. She was also observed pulling up her pants. Although the staff observed this privacy issue, at no time was direct care staff observed to redirect Client #7 to finish getting dressed in her room and/or the bathroom.	W 130	W130 This STANDARD will be met as follows: The QMRP will ensure that staff receive further in-service training on rights of residents and how to assist them in observing privacy; especially, given the following examples: 1. Appropriate clothing and adjustments to such clothing (i.e. longer shirts, belt, etc.) to reduce chance of exposing self. And 2. Closing bedroom/bathroom door during private time 5/31/07	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

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W 153	Continued From page 4 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of the investigative and incident reports and the review of the facility's Incident Management System (IMS), the facility failed to ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown origin were reported immediately to the administrator or to other officials as required by State Law [22DCMR Chapter 35 - 3519.10] through established procedures for three of seven clients residing in the facility. (Clients #1, #5, and #7) The findings include: The facility failed to ensure that all incidents were written and reported immediately to the administrator as evidenced below: a. Review of the facility's IMS on 4/11/07 at 1:00 PM, revealed an investigative report pertaining an alleged allegation of abuse. The investigative report revealed that on 2/20/07, staff witnessed another staff person being abusive to Client #1 by threatening to withhold food from her for various reasons and talking in harsh tones to the client. The report also revealed that the actual incident occurred on 2/18/07, but was not reported to the administrator for two (2) days.	W 153	W153 The standard will be met as evidenced by: Staff have been re-trained in implementing incident management procedures. Additionally, all staff have signed waivers, either upon hire or upon deployment, of their responsibilities in reporting abuse/neglect. The agency will strictly enforce its policies in holding individuals accountable, which may include termination for failure to report such occurrences. 5/10/07	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

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W 159	Continued From page 5 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's active treatment. The findings include: 1. The QMRP failed to ensure that an effective system was implemented to protect the clients' rights for privacy during personal care needs. [See W130] 2. The QMRP failed to ensure that all injuries of unknown origin were reported and/or in accordance with the facility's policy and procedures. [See W153] 3. The QMRP failed to ensure that staff implemented Client #3's Behavioral Support Plan (BSP). [See W193]	W 159	W159 This STANDARD will be met as follows: 1. Cross ref. W130 2. Cross ref. W153 3. Cross ref. W193	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility staff failed to demonstrate competency in implementation of Clients #2 and	W 193		

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W 193	Continued From page 6 #3's Behavior Support Plan (BSP). The findings include: 1. On April 10, 2007 at approximately 6:15 PM, Client #2 was observed going on a community walk along with her peers and staff, including the client's one to one staff. Approximately 30 minutes later, a staff telephoned the facility to report that Client #2 was agitated and may exhibit behaviors when returning to the facility. When the client returned to the facility, the client's one to one was interviewed about the client's behavior on the outing. The staff reported that the client walked out of the store when she could not have a bigger bag of potato chips. The staff acknowledged that the client had target behaviors that had not been observed since she had been assigned as the one to one in February 2007. The staff was asked if she was aware of the Client's behavioral strategies and interventions and was knowledgeable as to their implementation. The staff stated that she had not been trained on the client's BSP. On April 12, 2007, at approximately 12:00 PM, Client #2's BSP dated April 6, 2007 was reviewed. The BSP revealed the following target behaviors: 1) Noncompliance to medical appointment; 2) Noncompliance to general staff directives (refusing to attend day program, refusing to participate in assigned tasks, and overall refusals to follow staff directives); 3) Verbal aggression (cursing/using profanity at others, making insulting comments, and responding to hallucinations); 4) Stomping upstairs and slamming her bedroom door; 5) Property Destruction (throwing/breaking objects); 6) Verbal threats (threatening to engage in physical	W 193	W193 This STANDARD will be met as follows: Staff were trained on implementation of the BSP's for all residents on March 9, 2007. A second session was scheduled for those who missed the first offering. In addition, all staff are trained on behavior management prior to or upon deployment into the home. Additional measures will be taken as follows: 1. All staff have been re-trained on implementation of all BSP's including the one developed for client #2. Staff will not be assigned to support clients until they have a fundamental understanding of the BSP. This acknowledgement will be documented.	

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W 193	Continued From page 7 aggression towards others, and threatening to call the police or her sister); 7) Self-Injurious head banging (hitting head against the wall); 8) Auditory hallucination; and 9) Running into street. Interview with the Qualified Mental Retardation Professional (QMRP) on April 13, 2007 at approximately 1:30 PM confirmed that the staff had not received training on Client #2's BSP and stated that training on the BSP was scheduled for April 14, 2007. It should be noted that the one to one staff has been providing direct supervision since February 15, 2007. 2. On April 10, 2007, between 3:03 PM - 3:51 PM, Client #3 was observed rubbing her hair and head repeatedly. During this time frame, staff and other clients were involved in preparing dinner and participating in housekeeping activities. Client #3 was allowed to sit idle without any constructive activities or staff interaction. Review of the BSP, dated January 28, 2007, revealed that the client had targeted behaviors of "Trichotillomanic and Repetitive Face Rubbing". Further review of the BSP reflected that statement "Do not allow the client to be idle for long periods of time to avoid target behaviors." There was no evidence that staff implemented Client #3's BSP proactive strategies as prescribed in the plan.	W 193	2. Staff will receive additional training on implementing the active treatment routine for client #3 to properly support her in managing behavior. 3. The staffing pattern will be reviewed with the governing body to determine how best to support client #3 5/31/07	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 249		

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W 249	Continued From page 8 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility's staff failed to demonstrate competency in implementing Client #3's Behavior Support Plan (BSP). The finding includes: On April 10, 2007, between 3:03 PM - 3:51 PM Client #3 was observed rubbing her hair and head repeatedly. During this time frame, staff and other clients were involved in preparing dinner and participating house keeping activities. Client #3 was allowed to sit idle without any constructive activities or staff interaction. Review of the BSP, dated January 28, 2007, revealed that the client had targeted behaviors of "Trichotillomanic and Repetitive Face Rubbing". Further review of the BSP reflected that statement "Do not allow the client to be idle for long periods of time to avoid target behaviors." There was no evidence that staff implemented Client #3's BSP proactive strategies as prescribed in the plan.	W 249	W249 Cross reference response for W193 #2 & #3	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide written informed consent for the use of psychotropic medications and sedation for one of two clients included in the sample. (Client #3) The finding include: The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Client #1's psychotropic medications, Behavior Support Plan, and sedative medications prior to medical appointments. [See W124]	W 263	W263 Cross reference response for W124	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview, and record review the facility failed to provide follow-up preventive care for one of seven clients residing in the facility. (Client #7) The finding includes: Review of the unusual incident report log book conducted on 4/11/07 at approximately 1:00 PM revealed an investigation/incident report dated 6/12/06. The investigation report revealed that on 6/6/06 Client #7 arrived home from the day program and reported that her breast was hurting. The Residential Director observed a red swollen hard area on the client's breast in the same location of the previous bump thought to be a	W 322		

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W 322	Continued From page 10 mosquito bite. The facility's charge nurse observed the area and agreed that the client needed to be sent to the emergency room. Review of the "General Emergency Department Discharge Instructions, dated 6/6/07, revealed that Client #7 was diagnosed with abscess Breast V Inflammatory changes c/w Breast tumor. The discharge instructions also revealed that the client was to "follow-up with a physician in 2-3 days without fail." On 4/12/07 at 2:38 PM the facility's nurse was interviewed as to the status of the follow-up visit. The nurse stated that the emergency room discharge instructions were not included in the client's medical chart; and therefore, the client was not seen by a physician as ordered by the hospital. On June 12, 2006, 6 days after the initial emergency room visit, the client was taken to emergency room again due to continued pain in her breast. During this emergency room visit, the client was admitted to the hospital for surgical debridement of the breast abscess.	W 322	W322 The referenced incident had been investigated at the time of occurrence. It was determined that the discharge instructions were not seen by the nurse. Additionally, the investigation report notes that the discharge instructions were contradictory within itself and did not indicated what timeframe the client was to be seen ("follow up in 2-3 [blank] without fail without fail). Recommendations from that investigation included having the nurse review ER discharge instructions with the primary physician, who would determine the next course of action, within 24 hours of the emergency treatment. This recommendation remains in place. 5/10/07	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations, interview and record review the facility failed to ensure nursing services were provided in accordance with the needs of two of seven clients residing in the facility. (Client#3 and #7) The findings include:	W 331		

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W 331	Continued From page 11 1. The facility's nursing services failed to ensure that current Physician's Orders (PO) for Client #3's reflected Ensure Plus once a day. On April 10, 2007 at approximately 5:30 Client #3 was observed during dinner being served beef stew, biscuits, salad, peaches, water, and juice which were served family style. The client consumed 100% of the meal. Interview with staff indicated that the client was a good eater and had gained weight since last survey period. Review of Client #3's medical records on April 12, 2007 at 12:40 PM revealed current PO dated April 1, 2007. The PO revealed that Client #3's diet order included Ensure Plus one (1) can three times daily, however, the review of the Medication Administration Records at approximately 1:00 PM reflected that Client #3 received ensure once a day. Review of nutritional assessment, dated November 1, 2006, reflected a dietary recommendation to continue Ensure Plus once a day. On April 12, 2007 at 2:38 PM, the facility's charge nurse was interviewed to clarify the supplemental feeding order. According to the nurse, Client #3's order for Ensure Plus was decreased from one can three times daily to one can daily in October 2006. The charge nurse acknowledged that Client #3's diet order for ensure plus needed to be changed on the current PO. 2. Review of the unusual incident report log book conducted on 4/11/07 at approximately 1:00 PM revealed an investigation/incident report dated 6/12/06. The investigative report revealed that on 6/6/06 Client #7 arrived home from the day program and reported that her breast was hurting. The Residential Director observed a red swollen	W 331	W331 This STANDARD will be met as follows: 1. The current physician order has been corrected. All physician orders will be reviewed monthly to ensure accuracy in printing. Additionally, accuracy will be ensured through routine audits by the Director of Nursing and QA Departments. 2. Cross reference response for W322 5/10/07	

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W 331	Continued From page 12 hard area on the client's breast in the same location of the previous bump thought to be a mosquito bite. The facility's charge nurse observed the area and agreed that the client needed to be sent to the emergency room. Review of the "General Emergency Department Discharge Instructions, dated 6/6/07, revealed that Client #7 was diagnosed with abscess Breast V Inflammatory changes c/w Breast tumor. Further review of the discharge instructions revealed that the client was to "follow-up with a physician in 2-3 days without fail." On 4/12/07 at 2:38 PM the facility's nurse was interviewed as to the status of the follow-up visit. The nurse stated that the emergency room discharge instructions were not included in the client's medical chart; and therefore, the client was not seen by a physician as ordered by the hospital. On June 12, 2006, 6 days after the initial emergency room visit, the client was taken to emergency room again due to continued pain in her breast. During this emergency room visit, the client was admitted to the hospital for surgical debridement of the breast abscess.	W 331		
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure timely medical follow up for one of seven clients residing in the facility. (Client #7)	W 338		

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W 338	Continued From page 13 The finding includes: Record review of the unusual incident report log book conducted on 4/11/07 at approximately 1:00 PM revealed an investigative/incident report dated 6/12/06. The investigative report revealed that on 6/6/06 Client #7 arrived home from the day program and reported that her breast was hurting. The Residential Director observed a red swollen hard area on the client's breast in the same location of the previous bump thought to be a mosquito bite. The facility's charge nurse observed the area and agreed that the client needed to be sent to the emergency room. Review of the "General Emergency Department Discharge Instructions, dated 6/6/07, revealed that Client #7 was diagnosed with abscess Breast V Inflammatory changes c/w Breast tumor. Further review of the discharge instructions revealed that the client was to "follow-up with a physician in 2-3 days without fail." On 4/12/07 at 2:38 PM the facility's nurse was interviewed as to the status of the follow-up visit. The nurse stated that the emergency room discharge instructions were not included in the client's medical chart; and therefore, the client was not seen by a physician as ordered by the hospital. On June 12, 2006, 6 days after the initial emergency room visit, the client was taken to emergency room again due to continued pain in her breast. During this emergency room visit, the client was admitted to the hospital for surgical debridement of the breast abscess.	W 338	W338 Cross reference response to W322	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440		

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W 440	Continued From page 14 quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 4/11/07 at 3:11PM revealed the scheduled shifts are as follows: Weekdays/Weekends 1st Shift 7 AM to 3 PM - 2 PM to 3 PM 2nd Shift 3 PM to 11 PM - 3 PM to 11 PM 3rd Shift 11 PM to 7 PM - 11 PM to 9 AM Review of the fire drill log for March 2006 through to February 2007 revealed that the facility failed to hold fire evacuation drills for all shifts on a quarterly basis. Drills were not conducted on the third shift.	W 440	W440 The Residential Director will review the evacuation drills minimally every quarter to ensure that each shift has the minimum amount of practice drills. Reviews will be documented and any problems noted in the drills will be immediately reported to the QMRP. 5/31/07	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the implementation of infection control procedures to prevent communicable	W 455		

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W 455	Continued From page 15 infectious diseases for one of clients included in the sample. (Clients #1) The finding includes: On April 10, 2007 at approximately 5:40 PM, Client #1 spilled a peach from her bowl onto the table. The Client picked the peach up from the table using her hands and ate it. Interview with the direct care staff on the same day revealed that Client #1 often eats rapidly and spills food in the process. The direct care staff also revealed that they encourage the Client slow down and not to pick up or eat spilled food. There was no evidence that infection control procedures to prevent communicable infectious diseases were being implemented.	W 455	W455 This STANDARD will be met as follows: Staff will receive additional training on infection control by the Director of Nursing. 5/31/07	

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I 000	INITIAL COMMENTS A recertification survey was conducted from April 10, 2007 through April 13, 2007. This survey was initiated utilizing a fundamental survey process. Seven females with various degrees of disabilities reside in the facility. The survey sample was derived from a random sampling of four of the seven clients. The survey findings were based on observations in the group home and three day programs, interviews with clients, family member/guardians, staff and consultants. Also, the findings were based on review of records to include unusual incident and investigation reports. NOTE: Prior to the recertification survey, the state regulatory agency received the facility's internal investigative report on March 22, 2007. The investigation determined that Client #1 had been abused by Direct Care Staff #1 on February 18, 2007. The investigative report documented that Direct Care Staff #2 who witnessed the Direct Care Staff #1 speaking to client #1 in a harsh voice and threatening to withhold food; did not report this incident until two days later on February 20, 2007. Based on the investigative findings, the facility's management placed both Direct Care Staff #1 and #2 on administrative leave immediately upon notification. The internal investigative report recommended the following actions to be taken by the facility: 1. Implement disciplinary action on the staff person to include terminations for abuse to the resident; 2. Implement disciplinary action on the staff witnessing the incident of suspension and mandatory training;	I 000		

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I 000	Continued From page 1 3. Immediate mandatory incident report training for all residential/nursing staff; 4. Staff to be retrained on Client #1's Behavior Support Plan in the next 30 days; 5. Staff to be retrained on how to support Client #1 (weekday/weekend) in the next 30 days; 6. Staff to be retrained on how to document, to include the importance of daily/time documentation as review of records show that this is not done in the next 30 days; 7. QMRP to further address Client #1's behavioral issues with the Interdisciplinary team and to discuss this recent incident with the Human Rights Committee; and 8. Conduct bi-weekly meetings with the residents to allow them to discuss their concerns. The surveyor revealed that the facility had addressed these recommendation and implemented a system to ensure that clients were not subjective to further abuse.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was	I 090		

Health Regulation Administration

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I 090	Continued From page 2 maintained in a safe, clean, orderly, attractive and sanitary manner. The finding includes: Observation and interview with the Residential Director during the environmental walk through on April 13, 2007 beginning at 3:08 PM revealed that the bathroom located first floor right across from the kitchen had a strong urine smell.	I 090		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to maintain the interior and exterior of the GHMRP in a in a safe, clean, orderly, attractive, and sanitary manner. The finding includes: Observation and interview with the Residential Director during the environmental walk through on April 13, 2007 beginning at 3:08 PM revealed that the stairway leading to the third level had two arms detached from the base.	I 091	1090 The bathrooms will be cleaned and disinfected daily. 5/10/07 1091 The ballisters ["arms"] of the upper banister will be repaired by the maintenance department prior to 5/31/07.	
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.	I 135		

Health Regulation Administration

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I 135	Continued From page 3 This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 4/11/07 at 3:11PM revealed the scheduled shifts are as follows: Weekdays/Weekends 1st Shift 7 AM to 3 PM - 2 PM to 3 PM 2nd Shift 3 PM to 11 PM - 3 PM to 11 PM 3rd Shift 11 PM to 7 PM - 11 PM to 9 AM Review of the fire drill log for March 2006 through to February 2007 revealed that the facility failed to hold fire evacuation drills for all shifts quarterly. (Third Shift)	I 135	1135 cross reference response for W440 of the federal deficiency report.	
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on record review, the GHMRP governing body failed to review its policies and procedures annually. The finding includes: Review of the policy and procedure manual on	I 161	1161 The Policy and Procedures manual is reviewed and approved by the Director of Operations on an annual basis. Evidence of such review will be made available in the manual. 5/11/07	

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I 161	Continued From page 4 April 11, 2007 at approximately 1:10 PM failed to provide evidence that the manual had been reviewed and approved.	I 161		
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current contracts for licensed consultants. The findings include: On April 13, 2007 at 2:30 PM review of personnel records/training records revealed that the following consultants records were unavailable to verify current contracts at the time of the survey. (Pharmacist, Occupational Therapist, and Sex Therapist)	I 188	1188 The following consultant records will be available by 5/31/07: Pharmacist, Occupational Therapist. The facility has not used a sex therapist, therefore there is no active file for such an individual. If the need for the services of a sex therapist arises, the agency will provide such with a qualified individual who meets all regulatory requirements.	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206		

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I 206	Continued From page 5 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees. The finding includes: Review of the personnel files on April 13, 2007, the GHMRP failed to provide current health certification for the following: 1. Direct Care Staff a. [redacted] b. [redacted] - Med Nurse 2. Consultants a. Register Nurse - [redacted] b. Sex Therapist - [redacted]	I 206	I206 1a&b Health certificates will be obtained for staff [redacted] and medication nurse [redacted] by 5/31/07. 2a Health certificate for Registered Nurse [redacted] will be obtained by 5/31/07. 2b. cross reference response for I188	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview record review, the GHMRP failed to ensure the Department of Health, was notified of unusual incidents or events that	I 379		

Health Regulation Administration

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I 379	Continued From page 6 substantially interfered with each resident's health and welfare within twenty-four hours or the next work day. The findings include: The GHMRP failed to notify the Depart of Health of the aforementioned incidents within twenty-four (24) hours or the next day. On April 13, 2007, interview with the Qualified Mental Retardation Professional (QMRP) and review of a facility unusual incident report revealed the following: 1. On 2/24/07, Resident #2 was exhibiting maladaptive behaviors as indicated in her behavior support plan. Staff were unable to manager her aggression and the police was called. 2. On 6/12/06, Resident #7 was being treated with oral anti-biotics for a boil on her right breast. While being treated at the hospital, medical staff determined that the area required further treatment (possible surgical debridement) and was admitted. 3. See Federal Deficiency Report W153	I 379	1379 1&2 The agency is reviewing its policies on incident management to ensure the fail-safe notification of all regulatory bodies within the appropriate time allotted. 3 Cross ref. W153 of the federal deficiency report 5/31/07	